DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 8 — 0 0 5

2. STATE: Pennsylvania

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~July 1, 1997~~ JAN. 1, 1998

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subpart Z

7. FEDERAL BUDGET IMPACT: no fiscal impact in fy 97
a. FFY ~~XXX~~ 98 $ (1,132,041)
b. FFY ~~XXX~~ 99 $ 25,471,865

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
4.19A Pages 2a, 6, 6a, 14, 16, ~~17~~, ~~17a~~, ~~18~~, 19, 20 22, 23, 24 and 27

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
4.19 A Pages 2a, 6, 14, 16, 17, 17a, 18, 19 20, 22, 23, 24 and 27

10. SUBJECT OF AMENDMENT:
Negotiated agreement between Commonwealth and hospital industry.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Review and approval authority has been delegated to the Department of Public Welfare

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Feather O. Houstoun

14. TITLE:
Secretary of Public Welfare

15. DATE SUBMITTED:
3/31/98

16. RETURN TO:
Commonwealth of Pennsylvania
Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Policy, Budget and Planning
P.O. Box 8046
Harrisburg, PA 17105

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
SEPTEMBER 22, 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
Claudette V. Campbell

21. TYPED NAME:
CLAUDETTE V. CAMPBELL

22. TITLE:
ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

Payments for Direct Medical Education Costs

(a) The Department reimburses eligible hospitals the Medical Assistance inpatient costs for direct medical education, that are determined allowable under Medicare cost principles in effect as of June 30, 1985. For the period January 1, 1998 through June 30, 1999, providers that were eligible for direct medical education payments as of December 31, 1997, or otherwise become eligible during this term shall be eligible for direct medical education payments.

(b) Payments

(1) For the period January 1, 1998, through December 31, 1998, eligible providers shall receive quarterly payments based on the monthly payments set forth in (b)(1) converted to quarterly payments.

(2) For the period January 1, 1999 through June 30, 1999, eligible providers shall receive quarterly payments as set forth in (b)(1).

(c) Direct medical education payments shall be adjusted as necessary in accordance with the limitations set forth in Part V.

(d) Direct medical education payments shall be considered final and prospective and are not subject to cost settlement.

(f) The hospital's average cost per case is standardized to account for case mix by dividing the hospital's average cost per case as determined in (e) by its case mix index. The resultant value is referred to as the base year case mix adjusted cost per case. The hospital's case mix index is determined by:

(1) Identifying the total number of Medical Assistance DRG cases for the hospital for the base year from the Department's paid claims data.

(2) Summing the relative values of each of the cases identified in (f)(1) to establish an aggregate relative value amount for the hospital.

(3) Dividing the hospital's aggregate relative value amount determined in (f)(2) by the number of Medical Assistance cases determined in (f)(1) to establish an average relative value or case mix index for the hospital.

(g) Subject to limits under (h), hospital specific rates are determined by trending forward the case mix adjusted cost per case determined in subsection (f) by use of the following economic adjustment factors.

(1) increasing each hospital's case mix adjusted cost per case value determined in (f) by 4.5 percent to account for Fiscal Year 1987-88 inflation.

(2) increasing the value determined in (g)(1) by 5.6 percent to account for Fiscal Year 1988-89 inflation.

(3) increasing the amount determined in (g)(2) by 5.0 percent to account for Fiscal Year 1989-90 inflation.

(4) increasing the amount determined in (g)(3) by 5.3 percent to account for Fiscal Year 1990-91 inflation.

(5) increasing the amount determined in (g)(4) by 5.2 percent to account for Fiscal Year 1991-92 inflation.

(6) increasing the amount determined in (g)(5) by 4.6 percent to account for Fiscal Year 1992-93 inflation.

(7) increasing the amount determined in (g)(6) by 4.3 percent to account for Fiscal Year 1993-94 inflation. This inflation factor is applied effective July 1, 1993, for acute care general hospitals were eligible for volume or rural disproportionate share rate enhancements in Fiscal Year 1992-93. The inflation factor is applied effective January 1, 1994, for other acute care general hospitals.

(8) increasing the amount determined in (g)(7), effective January 1, 1995, by 3.7 percent to account for calendar year 1995 inflation.

(9) For the period January 1, 1996 to December 31, 1996, each hospital's case mix adjusted cost per case value in (g)(8) is the amount as of December 31, 1995, decreased by 5 percent to account for forecast error.

(10) For the period January 1, 1997 to December 31, 1997, each hospital's case mix adjusted cost per case value in (g)(9) is increased by 2 percent.

(11) For the period January 1, 1998 through December 31, 1998, each hospital's case mix adjusted cost per case value in (g)(10) is increased by 2.7 percent.

(12) For the period January 1, 1999 through June 30, 1999, each hospital's adjusted cost per case value in (g)(11) is increased by 2 percent.

(h) The amount determined under (g)(11) is limited to $6,443.72 for the period January 1, 1998 through December 31, 1998. The amount determined under (g)(12) is limited to $6,572.59 for the period January 1, 1999 to June 30, 1999.

Limits to Final Payments

The Department's payment for inpatient hospital services (including acute care general hospitals and their distinct part units, private psychiatric hospitals, and freestanding rehabilitation hospitals) may not exceed in the aggregate, the amount that would be paid for those services under Medicare principles of reimbursement.

The Department's payment, exclusive of any disproportionate share payment adjustment, may not exceed the hospital's customary charges to the general public for the services.

The Department will not pay a final audited per diem rate for the hospital or hospital unit that exceeds the ceiling, which is the hospital's audited per diem rate for the hospital or hospital unit for the preceding fiscal year increased for inflation by the following inflation factors:

(1) 5.6 percent to account for Fiscal Year 1988-89 inflation.

(2) 5.0 percent to account for Fiscal Year 1989-90 inflation.

(3) 5.3 percent to account for Fiscal Year 1990-91 inflation.

(4) 5.2 percent to account for Fiscal Year 1991-92 inflation.

(5) 4.6 percent to account for Fiscal Year 1992-93 inflation.

(6) 4.3 percent to account for Fiscal Year 1993-94 inflation.

This inflation factor is applied effective July 1, 1993, for all inpatient rehabilitation facilities which qualified for a disproportionate share payment, exclusive of supplemental disproportionate share payments, in Fiscal Year 1992-93. The inflation factor is applied effective January 1, 1994, for other inpatient rehabilitation facilities.

(7) Effective January 1, 1995, the amount determined under (6) will be increased by 3.7%.

(8) Effective January 1, 1996, the amount determined under (7) will be multiplied by .95.

(9) Effective January 1, 1997, the amount determined under (8) will be increased by 2%.

(10) Effective January 1, 1998, the amount determined under (9) will be increased by 2.7%.

(11) Effective January 1, 1999, the amount determined under (10) will be increased by 2%.

For the period January 1, 1998 through December 31, 1998, the Department limits interim and final payment to rehabilitation providers to $980.38 per day. For the period January 1, 1999 through June 30. 1999, the Department limits interim and final payment to rehabilitation providers to $999.99 per day.

DISPROPORTIONATE SHARE PAYMENTS

Part I. General Policy

The Department provides additional funding for in-state inpatient hospital providers which serve a disproportionate share of Medical Assistance recipients, or Title XIX or low-income patients, according to the provisions of Section 1923 of the Social Security Act. Hospitals and units which can qualify for disproportionate share payments under this part are acute care general hospitals; psychiatric, medical rehabilitation, and drug and alcohol rehabilitation units of acute care general hospitals; freestanding rehabilitation hospitals; and private psychiatric hospitals.

The Department will determine, effective July 1, 1998, the hospitals that qualify for disproportionate share payments, and the amounts of such payments, according to the standards described in this section. Days of care included in the eligibility determination include MA-HIO days of care, MA-HMO days of care, Medicaid administrative days, and days of care provided to recipients from other states' Medicaid programs.

No hospital may be defined as eligible for disproportionate share payments unless it has a Title XIX utilization rate of one percent or greater. In conformity with OBRA 93, effective July 1, 1995, the Department will establish disproportionate share payments no greater than each hospitals' unreimbursed costs for services rendered to Title XIX patients and uninsured patients.

(a) To qualify as a disproportionate share hospital, the hospital must meet one of the conditions set forth under subsection (b) and meet any one of the following conditions:

(1) Have a percentage of Title XIX Medical Assistance days to total days equal to or greater than one standard deviation above the mean for all in-state hospitals;

(2) Have a low-income inpatient utilization rate exceeding 25%;

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT HOSPITAL CARE
Part II. Disproportionate Share Payments to Acute Care General Hospitals

(a) Acute care hospitals that meet the conditions in Part I (a)(1) or (a)(2), are assigned a disproportionate share percentage ranging from 1 percent to 15 percent. Qualifying hospitals are ranked from high to low based on their ratio of total Title XIX days to total days. The qualifying hospital with the highest ratio of Title XIX days to total days is assigned a disproportionate share percentage of 15 percent. For each other hospital qualifying under this section, the disproportionate share percentage is:

(1) 1 percent, plus -

(2) 13 percent multiplied by a fraction: the numerator of which is the ratio of Title XIX days to total days of the qualifying hospital minus the ratio of Title XIX days to total days of the lowest hospital on the list of all such qualifying hospitals; and the denominator of which is the ratio of Title XIX days to total days of the second to highest hospital on the list of all such qualifying hospitals, minus the ratio of Title XIX days to total days of the lowest hospital on the list of all such qualifying hospitals.

(b) Acute care hospitals that meet the conditions in Part I (a)(3) receive a rural disproportionate share percentage ranging from 1 percent to 10 percent. Qualifying hospitals are ranked from high to low based on their ratio of Title XIX days to total days. The qualifying hospital with the highest ration of Title XIX days to total days is assigned a disproportionate share percentage of 10 percent. For each other hospital qualifying under this section, the disproportionate share percentage is:

(1) 1 percent, plus -

(2) 8 percent multiplied by a fraction: the numerator of which is the ratio of Title XIX days to total days of the qualifying hospital minus the ratio of Title XIX days to total days of the lowest hospital on the list of all such qualifying hospitals; and the denominator of which is the ratio of Title XIX days to total days of the second to highest hospital on the list of all such qualifying hospitals, minus the ratio of Title XIX days to total days of the lowest hospital on the list of all such qualifying hospitals.

(c) Hospitals that qualify under both the section (a) and section (b) will receive the higher of percentages, but will not receive both percentages.

(d) The Department prospectively calculates the annual disproportionate share payment amount for qualifying acute care general hospitals by multiplying the disproportionate share percentage determined under sections (a) - (c) by the hospital's projected Title XIX and general assistance income for acute care cases during the fiscal year.

(e) Annual payments are divided into four quarterly installments.

Part IV. Disproportionate Share Payments for Private Psychiatric Hospitals and Psychiatric Units Which are Subject to the Prospective Psychiatric Payment System

Private psychiatric hospitals and distinct part psychiatric units of acute care general hospitals that meet the conditions in Part I (a)(1) or (a)(2), or distinct part psychiatric units qualifying under Part I (a)(3) are assigned a disproportionate share percentage ranging from 1 percent to 10 percent. Qualifying providers are ranked from high to low based on total facility ratio of Title XIX days to total days. The qualifying provider with the highest ratio of Title XIX days to total days is assigned a disproportionate share percentage of 10 percent. For each other provider qualifying under this section, the disproportionate share percentage is:

(1) 1 percent, plus

(2) 8 percent multiplied by a fraction: the numerator of which is the ratio of Title XIX days to total days of the qualifying provider minus the ratio of Title XIX days to total days of the lowest provider on the list of all such qualifying providers; and the denominator of which is the ratio of the Title XIX days to total days of the second to highest provider on the list of all such qualifying providers, minus the ratio of Title XIX to total days of the lowest provider on the list of all such qualifying providers.

The Department prospectively calculates the annual disproportionate share payment amount for the qualifying psychiatric provider by multiplying the disproportionate share percentage obtained in this part by the provider's projected Title XIX and general assistance income for psychiatric days during the fiscal year.

Annual payments are divided into four quarterly installments.

Disproportionate share payments for private psychiatric hospitals and psychiatric units paid under the prospective psychiatric payment system are subject to the limitations set forth under Part V.

Effective January 1, 1998, the disproportionate share payments will be based on fee-for-service and managed care days.

Part V. Aggregate Limits to Inpatient Disproportionate Share, Outpatient Disproportionate Share and Direct Medical Education

For the period January 1, 1998 through June 30, 1998, the Department shall distribute to providers that are eligible for direct medical education payments and/or disproportionate share payments including outpatient disproportionate share, the aggregate, annualized amount of $175 million.

For the period July 1, 1998 through June 30, 1999, the Department shall distribute to providers that are eligible for direct medical education payments and/or disproportionate share payments including outpatient disproportionate share, the aggregate annualized amount of $175 million.

PROSPECTIVE PSYCHIATRIC PAYMENT SYSTEM

Private Psychiatric Hospitals and Distinct Part Psychiatric Units of Acute Care General Hospitals

General Policy

The Department pays for inpatient psychiatric services under a prospective payment system. Payment is made on a per diem basis. The prospective per diem rate for each provider is established using that provider's base year per diem costs trended forward by an inflation factor.

All compensable services provided to an inpatient are covered by the prospective per diem rate except for direct care services provided by salaried practitioners who bill the MA Program directly.

Costs are determined using Medicare principles unless otherwise specified. The Department does not follow the substance or retroactivity of the malpractice insurance cost rule established by 51 F.R. 11142 (April 1, 1986). Malpractice insurance costs are included in the administrative and general cost center and allocated according to established accounting procedures.

Payment Limits

The Department's payment for inpatient services (including acute care general hospitals and their distinct part units, private psychiatric hospitals, and freestanding rehabilitation hospitals) may not exceed in the aggregate the amount that would be paid for those services under Medicare principles of reimbursement.

The Departments payment, exclusive of any disproportionate share payment adjustment, may not exceed the hospital's customary charges to the general public for the services.

For the period January 1, 1998 to December 31, 1998, the Department limits the prospective per diem to $980.38. For the period January 1, 1999 to June 30, 1999, the Department limits the prospective per diem to $999.99.

Nonallowable Capital Costs

Capital costs for new or additional inpatient psychiatric beds are not allowable under the Medical Assistance Program unless a Section 1122 approval letter, a Certificate of Need, or a letter of nonreviewability had been issued for the additional beds by the Department of Health prior to July 1, 1991.

Capital costs related to replacement beds are not allowable unless the facility received a Certificate of Need or letter of nonreviewability for the replacement beds. To be allowable, the replacement beds must physically replace beds in the same facility and the capital costs related to the beds being replaced must have been recognized as allowable.

In addition to the above criteria, to receive payment for capital costs related to new, additional or replacement beds, the project must have been substantially implemented within the effective period of the original Section 1122 approval or the original Certificate of Need, including one six-month extension.

Calculation of Prospective Per Diem Rate

The prospective per diem rate of each private psychiatric hospital and distinct part psychiatric unit of an acute care general hospital will be determined as follows:

(a) The hospital or unit's reported Medical Assistance allowable inpatient costs from its Fiscal Year 1989-90 Cost Report (MA-336) are divided by its reported Medical Assistance inpatient psychiatric days.

(b) The amount determined under (a) is reduced by a 1.69% overreporting factor.

(c) The per diem cost determined in (b) will be inflated to the year for which the rate is being set using the following inflation factors:

(1) 5.3 percent to account for Fiscal Year 1990-91 inflation.

(2) 5.2 percent to account for Fiscal Year 1991-92 inflation.

(3) 4.6 percent to account for Fiscal Year 1992-93 inflation.

(4) 4.3 percent to account for Fiscal Year 1993-94 inflation. This inflation factor is applied effective July 1, 1993, for all inpatient psychiatric facilities which qualified for a disproportionate share rate enhancement in Fiscal Year 1992-93. The inflation factor is applied effective January 1, 1994, for other inpatient psychiatric facilities.

(5) Effective January 1, 1995, the amount determined under (c)(4) will be increased by 3.7%.

(6) Effective January 1, 1996, the amount determined under (c)(5) will be multiplied by .95.

(7) Effective January 1, 1997, the amount determined under (c)(6) will be increased by 2%.

(8) Effective January 1, 1998, the amount determined under (c)(7) will be increased by 2.7%.

(9) Effective January 1, 1999, the amount determined under (c)(8) will be increased by 2%.

(d) For an inpatient psychiatric provider whose first full fiscal year of operation under the Medical Assistance Program is subsequent to Fiscal Year 1989-90, the first full fiscal year of operation under the Medical Assistance Program will serve as its base year. The Department will pay full allowable Medical Assistance costs in the base year. Payment for subsequent years will be the audited per diem cost trended forward from the base year using the inflation factors described under (c).

(e) Effective January 1, 1998, the Department limits the prospective per diem to $980.38. Effective January 1, 1999, the Department limits the prospective per diem rate to $999.99.

Exclusions From the Prospective Psychiatric Payment System

(a) Inpatient psychiatric facilities which place a new capital project into service after the base year are entitled to payment for certain capital costs, provided the qualifying criteria are met:

(1) The costs related to the capital project must represent increases in the inpatient psychiatric facility's allowable depreciation and interest costs for a fixed asset that was entered in the inpatient psychiatric facility's fixed asset ledger in the year being audited.

(2) The costs must be attributable to a fixed asset that is:

(i) approved for Certificate of Need on or before June 30, 1991, in accordance with 28 Pa. Code Chapter 301 (Relating to limitations on Federal participation for capital expenditures) or 28 Pa. Code Chapter 401 (Relating to Certificate of Need program), or not subject to review for Certificate of Need as evidenced by a letter of nonreviewability dated on or before June 30, 1991; and

(ii) related to patient care in accordance with Medicare standards.

(b) In order for an inpatient psychiatric facility to qualify for an additional capital payment set forth in this section, the following criteria must also be met:

(1) The inpatient psychiatric facility's rate of increase in overall audited costs must exceed 15%.

(2) The inpatient psychiatric facility's rate of increase for allowable depreciation and interest must exceed its rate of increase for net operating costs.

(c) For Fiscal Years 1993-94 through 1998-99 for each inpatient psychiatric facility which requests an additional capital payment, the Department will audit its MA cost reports for the fiscal year for which the request is made, the prior fiscal year and all subsequent fiscal years for which additional capital payment is requested. To the extent that the facility is determined eligible to receive an additional capital payment under this section, the following applies:

AUGMENTED PAYMENTS FOR CERTAIN HIGH MEDICAL ASSISTANCE HOSPITALS

Effective July 1, 1993, the Department may make payments to certain high Medical Assistance hospitals to assure their participation in the Medical Assistance Program. For a hospital to qualify for such payments, the hospital must meet all of the following criteria:

1. At least 60 percent of the hospital's days of care must be provided to Medical Assistance recipients as reported in the hospital's FY 1991-92 Medical Assistance cost report.

2. The hospital must provide a broad spectrum of inpatient services as evidenced by its enrollment in the Medical Assistance Program as of June 30, 1993, as an acute care general hospital with at least two of the following types of excluded units enrolled:

   a. an excluded psychiatric unit;
   b. an excluded drug and alcohol detox/rehabilitation unit; or
   c. an excluded medical rehabilitation unit.

3. The hospital's liabilities exceed its assets as verified by the hospital's independently audited financial statements for FY 1991-92.

Hospitals qualifying under these criteria may be eligible for payments at a level adequate to assure the hospital's continued participation in the Medical Assistance Program and the continued availability of these services to the Medical Assistance population.

This augmented payment policy terminates effective July 1, 1999.

CHANGES OF OWNERSHIP

Effective July 1, 1993, no provider may have its rates rebased solely due to change of ownership.